2003

County Medical Services (CMS) Program

Hospital Handbook

CMS

Section I

CMS Program Overview

The San Diego County Medical Services (CMS) Program is a County funded, safety net program that provides physical health services to eligible medically indigent adults. Although the CMS Program reimburses specialty and ancillary providers at interim Medi-Cal rates, it differs from the Medi-Cal entitlement program. Services are limited to the Program Medical criteria and there are no co-payments. Medical care is provided to the CMS population only for acute illness and chronic conditions, which, if left untreated, would result in death or significant disability.

AmeriChoice

AmeriChoice serves as the CMS Program Administrative Services Organization (ASO) and administers day-to-day activities including case management and coordination of care, utilization review and prior authorization, patient and provider relations, claims payment, financial management and program development and analysis.

Questions and concerns about the operations of this program should be directed to:

AmeriChoice
CMS Program Provider Relations
PO Box 939016
San Diego, CA 92193
(858) 492-4422

Section II

Eligibility

Overview

To be eligible for CMS services, patient must:

- Have an immediate or long term medical need
- Be a US citizen or eligible alien
- Be a resident of San Diego County
- Be 21 through 64 years old
- Not be linked to Medi-Cal (aged, blind, CalWORKS or disabled)
- Be within CMS income limits or receive General Relief
- Be within CMS resource limits

Financial Criteria

Financial eligibility criteria for the CMS Program are based on resources and income. Resources include, but are not limited to: cash, funds in checking and savings accounts, and real property other than the patient's primary home.

The CMS Program sets a limit on monthly income based on family size after certain deductions. The chart below shows resource and income limits for the CMS Program.

	Resource Limits	Income Limits
Family Size	1989	(as of 7/1/01)
1	$2,000	802
2	3,000	1,084
3	3,150	1,366
4	3,300	1,648
5	3,450	1,930
6	3,600	2,212
7	3,750	2,493
8	3,900	2,775
9	4,050	3,058
10	4,200	3,339
Over 10	4,200	Additional $282.00/person

Citizenship/Eligible Alien Status

Patients must have U.S. citizenship or eligible alien status and must provide proof of status before certification.

Residency

Patients must live in a primary residence located in San Diego County and must provide proof of residence before certification. A fixed address is not required. Patients living on the streets or in a vehicle can be county residents. Patients "visiting" from other counties, states, or countries are not eligible.

Eligibility Appointments

Human Services Specialists (HSS) are located in select Community Health Centers and Public Health Centers and local hospitals. HSSs are County employees responsible for determining CMS eligibility. Eligibility appointments with HSSs at the Community Health Centers and Public Health Centers are scheduled by calling (800) 587-8118. Eligibility appointments with HSSs at the hospitals are scheduled by hospital staff or the Hospital Outstation Services (HOS) HSS.

Standard Eligibility

Patients apply for standard eligibility by completing an application and providing verifications to an HSS. The HSS reviews the application and verifications, and makes the decision to approve or deny. The HSS issues the decision in a notice of action to the patient. The HSS provides a CMS ID card and Patient Handbook to approved patients. Initially, patients are approved for a period of 1 to 6 months. Patients receiving General Relief do not complete an application or submit verifications. After verifying the patient's identity and receipt of General Relief, the HSS gives the patient a CMS ID card and a Patient Handbook. Upon renewal, patients with asthma, diabetes and/or hypertension may be approved eligibility for up to 12 months.

Temporary Eligibility

- Emergency Room Application: Patients can apply for coverage for a single emergency room visit by completing an Emergency Room application at a contracting hospital.

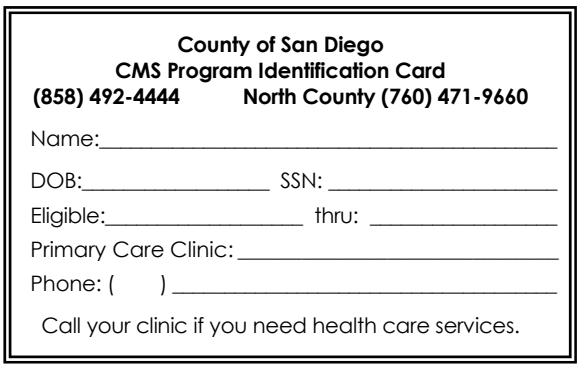
- Urgent Primary Care Application: Patients can apply for short-term eligibility (20 days) at some community health centers by completing an Urgent Primary Care application.

Immediate Care

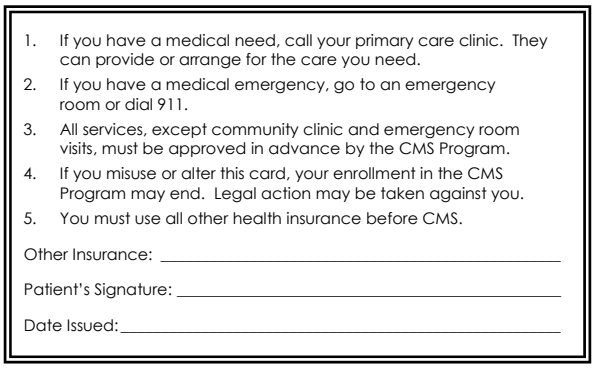
When a non-certified patient requires immediate medical care that the clinic cannot provide, the patient should call the CMS Patient Information Line (858) 492-4444 or from North County (760) 471-9660. The Administrative Services Organization (ASO) will evaluate the patient's medical need and if all CMS criteria are met, the ASO will contact the County Health Care Access Division (HCAD) to schedule an urgent eligibility appointment. Following notification of approved eligibility, the ASO will arrange and authorize appropriate care.

CMS Identification Card

CMS patients with standard eligibility receive a CMS Identification Card and a Notice of Action (NOA). The ID card and NOA are proof of eligibility; however, they do not authorize services. An example of the CMS Card is shown below:



Front



Back

All non-emergent services must be prior authorized. Authorization of services cannot be generated until the patient's eligibility is entered into the CMS Program Information System.

Fraud Referral

When you suspect that a patient is not eligible for CMS, you should call the Patient/Provider Coordinator at (858) 492-4422. You should be able to give the patient's name, address, birth date, and social security number and the reason you suspect fraud. You can remain anonymous.

Section III

Physical Health Services

The CMS Program covers medical services for serious health problems, which, if untreated, could be life threatening or significantly disabling. ASO medical staff is responsible for determining if a patient's medical condition meets the County's medical program criteria.

Covered Services

Services covered by the CMS program that **do not** require prior authorization:

- Evaluation by a primary care provider
- Follow-up care by a primary care provider for serious or chronic health conditions
- Consult with a specialty physician when ordered by the primary care provider
- Emergency room care
- Emergency hospital admissions
- Emergency medical transportation
- Emergency dental care
- Formulary medications

Services covered **only when prior authorized** by the CMS program:

- Care by a specialist
- Scheduled hospital admissions
- Surgical and diagnostic procedures
- Limited rehabilitation, medical equipment and home health services
- Non-emergency medical transportation
- Optometry exams and supplies
- Non-formulary prescription medications

Not Covered Services

The following services/diagnoses are **NEVER** covered:

- Pregnancy and all services during a pregnancy
- Pediatrics
- Family Planning
- Infertility services
- Sterilization procedures
- Mental Health services
- Drug and Alcohol Treatment
- HIV+ (early intervention) care by primary care
- Organ and bone transplants and all related services
- Bone marrow transplants
- Experimental Procedures
- Cosmetic Procedures in the absence of trauma or significant pathology
- Non-emergency dental and vision care
- Routine or work examinations
- Completion of medical certificates
- Counseling for lifestyle problems
- Orthodontia
- Non-prescription medications
- Emergency room visits for after care, follow-up, and to obtain prescriptions

Section IV

Prior Authorizations and Physician Responsibilities

The CMS Program reimburses providers for services provided when the patient has been certified for CMS AND the services have been **prior authorized**. The physician's office is responsible for:

- Verifying that the patient is certified for the CMS Program.
- Verifying that non-emergent services to be provided to the patient have been prior authorized by the CMS Program
- Providing the ASO with sufficient documentation to determine the severity of the patient's condition.
- Submitting a plan of treatment
- Assuring prior-authorization for continued treatment and/or referrals
- Submitting claims in the format and time frame required by the CMS Program

Section V

Inpatient and Emergency Room Services

Emergency Admissions

CMS contracting hospitals must notify the ASO within twenty-four (24) hours (extended to the first day following a weekend or holiday) of any admission of a CMS (or potential CMS) patient. Requests for retroactive authorization of CMS (or potential CMS) patient admissions must be made within ten (10) days of the admission date in order to be considered. The hospital stay is subject to retrospective medical review by the ASO, which may result in disallowance of all or some inpatient days.

The final status of the admission is based on the eligibility determination process, the diagnosis, and the patient's length of stay. The patient's eligibility determination may take several weeks to complete and the ASO generates authorization numbers only for certified patients. Inpatient authorizations are global and include facility, equipment and all technical and professional services for the hospital stay.

Scheduled Admissions

Scheduled, non-emergent admissions and outpatient surgical procedures must be prior authorized by submitting a Treatment Authorization Request or written request. The ASO sends written confirmation to both the ordering physician and the facility that indicates the approved procedure(s) and the valid dates for the service.

Post Discharge Care

- One (1) post discharge office visit to the physician is covered within thirty (30) days following an approved inpatient stay
- Diagnostic tests (lab, x-ray, EKG, etc.) require separate authorization
- Ancillary services such as durable medical equipment and home health require separate authorization

Emergency Room (ER) Services

Approved emergency services must meet the following conditions:

- The patient must show a valid CMS ID card or complete the CMS Emergency Department Episode Application
  - The ER and associated services are covered for CMS certified patients (CMS cardholders) at both contracted and non-contracted hospitals
  - The ER and associated services are covered for a patient with an approved ER Episode Application only at contracted hospitals
- The condition must be one that is listed in the CMS Covered Services Section III Page 1 of this handbook and must be medically necessary **(ER visits for follow-up or prescriptions are not covered.)**
- The place of service listed on the claim form must be the ER

Covered Emergency Room Services

- All facility, technical services and supplies provided during the emergency room episode are included in the hospital's reimbursement
- Emergency physician, specialty physician and ambulance services are claimed and paid separately and must have occurred during the approved ER episode
- DME that is given to the patient during or after the ER episode is paid separately only when authorized by CMS

Emergency Room Follow-Up

All patients must receive information about how to obtain follow-up care through the CMS Program when they are discharged from the ER. A sample of the CMS Emergency Department Episode Application (CMS-35, CMS-36, CMS-37) packet is found in Attachment B.

- Certified patients are encouraged to contact their primary care physician for continued care or referral and should be reminded that follow-up care at the ER is not covered by CMS
- Standard eligibility and prior authorization are required for additional services, including follow-up by a specialty physician

Section VI

Medical Management

CMS has registered nurses who hold valid California nursing licenses and case management credentials. The nurses review face sheets from contracting and non-contracting hospitals of patients who are CMS certified or who are pending certification for high-risk indicators. The nurses review the medical records of selected patients to determine if:

- Continued inpatient care is medically warranted
- There is a discharge plan
- The discharge plan is current
- The discharge plan is safe and appropriate
- The patient requires placement upon discharge
- The discharge planner has started the placement process
- A referral to Medi-Cal for a disability evaluation is appropriate
- The length of stay is appropriate

Case Management

This section describes the responsibilities of hospital discharge planners and the ASO Case Managers in developing an appropriate medical and psychosocial plan. A discharge plan should try to minimize the risk of re-admission.

Discharge Planning

Referral for Placement

When the hospital discharge planner identifies a patient, who needs placement in a room and board or board and care facility, the discharge planner must notify the ASO Case Management section. To qualify for placement the patient must:

- Live in an inadequate environment or lack support from family or friends
- Need care and supervision following hospitalization or
- Require stabilization due to medical condition
- Be certified for CMS
- Have approval for placement by an ASO Case Manager

Referral of High-Risk Patients

The discharge planner should call the ASO Case Management staff at (858) 495-1300 when a certified patient is an inpatient with one or more of the following high-risk indicators:

- Tuberculosis (TB)
- Transportation (based upon medical need)
- Homelessness (concomitant medical diagnosis is required)
- Drug and/or alcohol abuse
- Limited mental functioning
- Mental retardation
- Illiteracy
- Multiple physicians
- Complex or chronic medical conditions

The discharge planner must give the following information to the ASO Case Manager:

- Patient name
- Social Security Number
- Date of birth
- Date of admission
- Projected date of discharge
- Diagnosis
- Discharge plan request
- Hospital room number
- Medical records (progress notes upon request)

The ASO Case Manager will:

- Make a hospital visit
- Complete an intake form
- Review the patient's chart
- Assess the patient for the appropriate level of care
- Locate a room and board or board and care facility, and arrange placement
- Notify the discharge planner of the location of the facility (Note: hospitals are

responsible for providing transportation upon discharge)

- Initiate a Medi-Cal disability referral, if appropriate, to HOS

Medication upon Discharge

The hospital is responsible for providing no less than a full course of antibiotics and/or 3-day supply of medication as indicated at time of discharge to avoid unnecessary complications after hospitalization.

Services and Equipment after Discharge

The hospital discharge planner must submit all requests for ongoing services and equipment needed after discharge to the ASO Case Manager for authorization. The ASO Case Manager will evaluate the patient for:

- Acute inpatient rehabilitation
- Outpatient rehabilitation
- Home health
- Home infusion
- Durable medical equipment

The ASO Case Manager may ask the discharge planner for additional information such as H&P OP reports, lab results, MRI results, PT/OT/ST notes, discharge summary and/or instructions.

In Home Care

For patients discharged home, the ASO Case Manager can authorize certain services and medical supplies including the following:

- Nursing assessments
- Wound care
- Home infusion therapies
- Home rehabilitation therapies
- Durable medical equipment (DME)

Treatment Plans

ASO Case Managers coordinate treatment plans by authorizing inpatient and outpatient rehabilitation, assisting with scheduling services, and making referrals to other community-based services.

Transportation

ASO Case Managers can help certified patients get transportation to medical appointments.

Public Assistance

ASO Case Managers can help certified patients apply for other benefits such as General Relief (GR), Medi-Cal Disability, and Supplemental Security Insurance (SSI).

Contracting Facilities

A listing of primary care clinics, contracting hospitals and pharmacies can be found in Attachment A.

Section VII

Claims

Overview

The ASO Claims Department processes all claims submitted by hospitals, clinics, specialty physicians and ancillary providers seeking payment from the CMS Program.

Submission Requirements

All claims must:

- Be for services and service dates that match the certified patient's eligibility and period authorized
- Be submitted electronically or on the Universal Billing Form (UB92) Note: When the patient has other health coverage (OHC), you must submit a claim to the other insurance carrier first, and then attach the other carrier's EOB to the UB92 before submitting your claim to CMS
- Include the following information:
  - Patient name, birth date, and Social Security Number
  - Date(s) of service
  - Place of service
  - Vendor and group name, address and phone number
  - Name and address of facility where services were rendered (if different from the billing office)
  - Medi-Cal Provider number
  - Provider Tax ID number
  - ICD-9 Codes
  - Current RVS, CPT, HCPCS, DRG and Medi-Cal codes as indicated
  - Authorization number (TAR control number)
  - Referring physician required
  - Full itemization of charges including drugs and supplies provided
  - All documentation and attachments required by Medi-Cal
  - Catalogue page or invoice when submitting an unlisted or "miscellaneous" code

- Summary or charges by Revenue Code – inpatient only
- Be submitted within 30 (thirty) days from the date of services but no later than July 31 to:

AmeriChoice, ASO
County Medical Services (CMS) Program
Claims Department
PO Box 939016
San Diego, CA 92193

Checking Claim Status

The ASO processes claims that are complete and accurate within 30 (thirty) days of receipt. If you have not received payment within forty-five (45) days, you must call (858) 495-1333 to ask about the claim's status.

Reimbursement

Checks and the Remittance Advice (RA) are produced on twice a month basis. CMS reimbursement is considered payment in full.

You may not bill patients for:

- Any balance of fees or other associated costs after CMS pays for the service(s)
- Any hospital administrative errors (incorrect coding, failure to obtain timely authorization or late submission)

You may bill patients for:

- Unauthorized services
- Services not covered in the CMS Program Scope of Services

Notification of Changes to Provider Information

To ensure that your check is accurate and timely, immediately notify ASO Claims Department at (858) 495-1333 of any changes in:

- Ownership
- Address (mailing and/or service site)
- Group affiliation
- Tax identification (TIN)

Medi-Cal Pending

CMS covers necessary medical care for certified patients while their Medi-Cal disability evaluation is pending. The ASO will process claims for these patients following standard CMS procedures.

Medi-Cal Approved

CMS will notify providers of the Medi-Cal approval on the RA. CMS will deny all claims received after the patient has been approved Medi-Cal. For claims that CMS has paid:

- If the date of service is within the current fiscal year, the hospital shall seek reimbursement from Medi-Cal and CMS will back payment out.
- If the date of service is in prior fiscal years, the ASO shall seek reimbursement from Medi-Cal. Medi-Cal may require prior authorization and medical documentation for specified procedures from CMS; therefore you are required to provide this documentation including medical records, and Medi-Cal provider numbers upon request

Hospitals shall notify the ASO, within ten (10) working days of being notified that a CMS certified patient has been approved Medi-Cal.

Appeal Process for Denied Claims

When you disagree with the level of payment or the denial of a claim, you must submit a written appeal within thirty (30) days of the denial notification. Clearly state the reason for the appeal and provide additional justification for payment. Send all documentation for the appeal to:

CMS Program – Appeals
Attention: Claims Department
PO Box 939016
San Diego, California 92193
FAX: (858) 495-1329

If you have questions, call the Claims Department at (858) 495-1333 for instructions about submitting your appeal. The ASO will review the claim and additional information and notify you of the decision within forty-five (45) calendar days.

Section VIII

Attachments